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Practice Management

The Medicare Audit and Appeals Process: A Guide for Interventional Pain Practitioners

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Background: Health care is a highly regulated industry and interventional pain physicians (IPPs) are right in the government's bull's eye. Over the next few years, IPPs will find themselves responding to audit requests from Medicare. An IPP's response to a Medicare record request should be tailored specifically to the type of request and the specific circumstances of the IPP. With so much at stake, IPPs should not underestimate the importance of an immediate and thoughtful response.

Objectives: This article discusses 1) the various types of record requests used by Medicare, 2) the practical steps an IPP should take in response to a record request, 3) the Medicare appeals process, and, 4) the practical steps an IPP should take in connection with the appeals process.

Discussion: IPPs should maintain an effective compliance program and ensure that medical records are appropriately documented before any audit takes place. If a Medicare audit decision is unfavorable, IPPs should understand the available appeals process and the steps that need to be taken to win the appeal.

Conclusion: With advance preparation and a considered response, IPPs can positively influence the outcome of a Medicare audit.

Key words: Medicare audit, appeals process, interventional pain management, interventional pain practitioners, Office of Inspector General (OIG), Comprehensive Error Rate Testing (CERT), Carrier Medical Review Program, Recovery Audit Contractor (RAC) audits

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Interventional pain practitioners (IPPs) find themselves in the uncomfortable position of being a target of the Office of Inspector General (OIG), with claims of fraud and abuse with increasing health care crisis (1-11). The OIG's Work Plan for 2008 states:

> We will review Medicare payments for interventional pain management procedures. Section 1862(a)(1)(A) of the Social Security Act provides that Medicare will pay for services only if they are medically necessary. Interventional pain management procedures consist of minimally invasive procedures, such as needle placement of drugs in targeted areas, ablation of targeted nerves, and some surgical techniques. Many clinicians believe that these procedures are useful in diagnosing and treating chronic, localized pain that does not respond well to other treatments. Interventional pain management is a relatively new and growing medical specialty. In 2005, Medicare paid nearly $2 billion for these procedures. We will determine the appropriateness of Medicare payments for interventional pain management procedures and assess the oversight of these procedures (11).

IPPs are already feeling the impact of the OIG's focus on interventional pain practices. In September 2008 the OIG published a report called "Medicare Payments for Facet Joint Injection Services" (11). In this report the OIG expressed its opinion that 63% of facet joint injections allowed by Medicare in 2006 did not meet Medicare program requirements resulting in approximately $96 million dollars in improper payments (2). Moreover, the OIG has signaled its interest in other issues relevant to IPPs in its Work Plans for the last several years including: 1) place of service errors; 2) "incident to" services; 3) qualifications and appropriateness of staff; 4) medical necessity; 5) documentation; and, 6) quality of care (1).

With the government's fraud and abuse detection efforts at an all-time high, IPPs must fully understand: 1) the ways in which the Center for Medicare and Medicaid Services (CMS) conducts audits; and, 2) the appeals process available to them in the event of an unfavorable audit. This article will explore the various types of Medicare audits, the Medicare appeals process, and the practical steps that IPPs can take to minimize the negative impact of an audit.

The Types of Medicare Audits

The Medicare program uses a number of different types of audits to detect perceived fraud and abuse among providers. These audits may differ in scope or may be conducted by different entities on behalf of the Medicare program, but each and every type of audit can result in a demand by CMS to refund payments.

Comprehensive Error Rate Testing

CMS established the Comprehensive Error Rate Testing (CERT) program to monitor the accuracy of Medicare fee for service payments. CMS typically retains third party contractors to conduct CERT audits. The CERT process begins with the Medicare program identifying procedure codes that statistically appear to be the subject of potential incorrect billings and/or payments. Once the procedure codes are identified, the CERT contractor randomly selects claims made with the procedure code for a probe audit and sends the identified provider a letter requesting copies of relevant medical records. Generally Medicare does not pay the claims requested in a CERT audit until the review substantiates the appropriateness of payment.

Upon receipt of the medical records, the CERT contractor reviews the records to determine whether the claims and medical records comply with the Medicare coverage, documentation, coding, and billing rules. When performing these reviews, the CERT contractor must follow Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and Local Coverage Determinations (LCDs) made by the applicable Medicare claims processing contractor. The CERT contractor does not develop or apply its own coverage, payment, or billing policies.

If the CERT contractor determines that the records and claims do not substantiate payment it sends the provider a letter denying the reviewed claims. Moreover, negative findings from a probe audit often lead to a more extensive post-payment audit and subsequent repayment demands for "erroneous" claims (12).

The Carrier Medical Review Program

As the name suggests, the Carrier Medical Review Program Audits (MR audits) are conducted by the Medicare carriers under Part B of the Medicare program and are designed to uncover erroneous documentation, billing, and/or Medicare payments.

Providers are selected for an MR audit for a variety of reasons including atypical billing patterns, specific identified billing issues, anonymous complaints, and/or volume of services provided. Often providers are singled out for an MR audit if their utilization for a given service exceeds that of their peers.

Most MR audits are usually conducted on a post-payment basis and begin with a probe review where the carrier reviews a sample of claims to determine whether services were medically reasonable and necessary and correctly paid. Some MR audits are automated and denials can be generated based on statistical and/or coding information. For example, the Medicare carrier may determine that claims for facet joint injections should be denied because they were billed on the same day as an epidural steroid injection or the carrier may deny based on the edicts of the Correct Coding Initiative.

In other cases the provider receives a letter requesting documentation for certain patients on specific dates of service. The carrier reviews and analyzes the documentation sent in by the provider to determine whether the services were fully and completely documented, medically necessary, and correctly billed (13).

Upon the conclusion of the probe review the Medicare carrier can take any of the following steps:

1. Refrain from action based on appropriateness of documentation and services.
2. Provider Notification and education.
3. Make a demand for repayment.
4. Place a provider on pre-payment utilization review which consists of medical review of claims prior to payment.
5. Conduct an expanded post-payment audit. Carriers are authorized to review a relatively small number of claims and then to use statistical sampling to extrapolate any denials to an entire universe of claims for a designated period of time.
6. Refer the case to the OIG for further investigation for potential fraud and abuse (14,15).

Recovery Audit Contractor (RAC) Audits

RAC audits are unique in that they are provided by independent companies whose payment for the audit services provided is based on a percentage of the money recovered for the Medicare program (16).

The use of RACs was first authorized as a demonstration program in 2003 (17,18). CMS initially developed the RAC demonstration program to determine whether the use of RACs would be a cost-effective means of ensuring that correct payments are being made to providers. From the government's perspective, the demonstration program, which began in March 2005 and ended in March 2008, proved so successful that RACs are now scheduled to be in place in every state by 2010 (16).

RACs are tasked with identifying and correcting improper payment for Medicare services. RACs are supposed to identify both overpayments and underpayments and collect the overpayments and facilitate the repayment of the underpayments. Not surprisingly, CMS has indicated that about 96% of the corrected claims identified by RACs are overpayments to providers and only 4% are underpayments (19).

Like CERT contractors, RACs are bound by statutes, regulations, CMS NCDs, payment and billing policies, and LCDs; RACs do not develop or apply their own coverage, payment, or billing policies.

RACs use proprietary software to identify claims that may have received improper payment. If the payment can be determined incorrect based solely on computer data available to the RAC (e.g. in contravention of the Correct Coding Initiative), the RAC will make an overpayment demand and request a refund from the provider. In most cases, however, the RAC requests the medical records from the provider, reviews the claims and medical records, and then makes a determination as to whether the claim contains an overpayment, an underpayment, or a correct payment.

The use of RACs is not without controversy. Providers find the RAC system burdensome because it takes significant resources to respond to the voluminous record requests and to defend denied claims. Additionally there is a concern that paying the RACs on a contingency basis incentivizes RACs to deny claims for issues such as documentation or medical necessity, areas which are highly subjective and often disputed by providers (20,21).

Nonetheless, CMS reports that it collected over one billion dollars from the RAC program between its start in 2005 and the conclusion of the pilot program in 2008. Moreover, only 4.6% of RAC overpayment determinations were overturned on appeal (17,18).

Practical Strategies for Preventing Adverse Audit Findings

For IPPs the likelihood is that they will be the subject of a Medicare audit at sometime during their career. The primary objective when faced with a Medicare audit is to effectively input the audit process to achieve a positive audit result. In the event that the audit result is not positive, the provider's objective should be to preserve all appeal rights and, eventually, to win the case during the appeals process. There are a number of steps that IPPs can take to meet their objectives.

Before the Audit

IPPs can take proactive measures to minimize the potential negative effect of an audit. The implementation and maintenance of an effective compliance program can assist the IPP in ensuring that all of the group's providers are fully and completely documenting the medical record and that the medical record is driving the correct coding of the services. A discussion of the elements of an effective compliance program is beyond the scope of this article. However, a good starting point for any IPP is the "OIG Compliance Program for Individual and Small Group Physician Practices (22)."

IPPs should also educate their staff regarding Medicare audits and responses before an audit occurs. For example, all staff should understand the protocol to follow if an auditor shows up at the office or if the practice receives an audit letter. The protocol should include 1) the designation of a point person to handle

the audit; 2) the requirement that all audit requests be immediately given to that point person; 3) an understanding that the staff does not have to speak with the auditors and should refrain from signing any documents provided by the auditors; and, 4) a method for documenting and confirming what records and other documents were provided to the auditor.

During the Audit

Most audits begin with a request for records. Providers often make the mistake of sending in the requested records without first conducting a review of the records. Their audit submission may vary depending on the documentation and/or billing issues, if any, raised in the records. IPPs should work with qualified legal counsel and consultants well versed in issues related to interventional pain practices to carefully review requested records and to consider the following steps and strategies:

1. Ensure that all deadlines are met. If it appears that the IPP will need more time to compile the audit documents, its representative should contact the auditor for an extension of time and should, of course, keep written confirmation that the time extension was granted.
2. Review the record request to see if there are any connections between the records. Identifying connections will give the IPP an idea of the issues surrounding the audit request. For example, do all of the records involve the same procedure code? Are all of the records for narcotic management? Are the services in each record provided "incident to"?
3. Compile the following documents for review by the IPP's legal counsel and qualified consultant:
    a. The audit letter.
    b. Copies of the entire medical record for each patient whose records are part of the audit. The IPP should not limit the copies to the dates of service requested in the audit letter because services provided prior to, and after, the requested date of service are often useful in substantiating the appropriateness of the service under review.
    c. Information on any previous audits or correspondence that may impact the current audit. For example, if the IPP was the subject of a previous audit for the same types of services and the carrier determined that the services were appropriate in the previous audit, the IPP may consider providing that helpful information to the current auditor.
    d. Relevant internal reports such as total Medicare payments for all codes and for the codes in the requested records. For example, if Medicare paid a total of $200,000.00 for all facets provided during the audit period, and the auditor makes an overpayment demand of $250,000.00 based on a statistical sample the IPP may want to retain a statistician to review the extrapolation.
4. If the records are illegible, the Medicare auditor is more likely to deny the services. Providers can counteract this problem by submitting not only the illegible records but also a word for word dictation of the records.
5. Work with legal counsel to review all Medicare authorities such as Local Carrier Decisions to determine if the records meet the Medicare documentation and medical necessity requirements.
6. Work with the consultant to determine whether the medical records support the services billed. Because medical services are not provided in a vacuum it may be helpful to submit records for dates of service before and/or after the requested audit dates of service.
7. Consider retention of experts such as well regarded IPPs. If the experts believe that the Medicare criteria were met, the IPP may consider providing an affidavit from the expert along with the medical records.

IPPs should be certain to keep copies of all submitted documents and to provide the documents to the auditor in a way that provides proof of submission (e.g. certified mail, return receipt requested). Once the records are submitted the IPP must wait for the results of the audit. If the audit results are unfavorable then the IPP should consider an appeal.

The Appeals Process

Whether the audit determination comes from a CERT audit, an MR audit, or a RAC audit, the appeal process is the same. The first step is the receipt of an adverse initial determination. The next steps are as follows (23):

Level 1: Redetermination

A redetermination is a request that the carrier

take another look at the audit findings. Redetermination is an independent on-the-record review of the initial determination. The carrier is supposed to have the claims reviewed by auditors who did not take part in the original adverse determination. The request for redetermination must be submitted within 120 calendar days from receipt of notice of the initial determination.

Level 2: Reconsideration

If the redetermination is unfavorable then the next level of appeal is to a Qualified Independent Contractor (QIC). Providers must submit their request for reconsideration in writing within 180 calendar days from receipt of notice of the redetermination. Importantly, the provider must submit all evidence at this stage of the appeals process. Failure to submit evidence at this stage could preclude subsequent consideration of the evidence. The requirement to provide evidence at this stage of the appeals process can be problematic to providers who have encountered difficulty obtaining the underlying data, policies, and other audit documents from the RAC. Providers must be vigilant in requesting and obtaining all relevant documentation from the RAC prior to this stage of the appeals process.

Providers should also ensure that their legal counsel is raising some common legal defenses to the audit including: 1) waiver of liability (24); 2) provider without fault (25); and, 3) the treating physician rule.

Level 3: Administrative Law Judge Hearing

Unfavorable reconsideration decisions can be appealed to an Administrative Law Judge (ALJ). The ALJ level is independent of the RAC contractor. The provider must file the request for an ALJ hearing within 60 days of receipt of the reconsideration decision.

Unlike the lower levels of appeal, the ALJ hearing provides an opportunity to provide evidence via witnesses such as the provider, coding experts, and medical experts. In most instances the hearings are held via conference call or video-teleconference. In person hearings may be granted if good cause is shown, but in person hearings are not the norm. IPPs should be prepared to be present and testify at the hearing. The IPP's testimony will be the strongest weapon in the arsenal but it may also be prudent to produce expert witnesses at the hearing to support the appropriateness of the documentation and coding of the services.

Level 4: Medicare Appeals Board

Providers can file appeals to the Medicare Appeals Board within 60 days of receipt of the decision of the ALJ. Importantly, CMS or the Medicare carrier can also request an appeal from the ALJ determination; and the Appeals Board can decide to hear an appeal of its own accord. The Appeals Board review is on the record so no in person testimony is allowed.

Level 5: Federal District Court

The final step in the appeals process is to the Federal District Court. This appeal must be filed in writing within 60 days of the Appeal Board decision.

Conclusion

Although IPPs should be concerned about the probability of a Medicare audit, there are proactive steps to take to minimize the risk of an adverse outcome. A compliance with the Medicare rules, regulations, and policies is the best defense to an audit. A thorough familiarity with the types of Medicare audits is essential to successfully navigating the ins and outs of the audit. And finally, a comprehensive approach to the audit and, if necessary, to an appeal of the audit determination, can lead to a positive outcome for the IPP.

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